

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Perry Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 mos. 13 days  
 Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Maryland  
 How long in hospital or institution? Since September 1946

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County \_\_\_\_\_  
 City or town Fairfax  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. P.O. Box #27  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW-I

## 3. (a) FULL NAME

BAKER, Robert Oliver

## 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widower  
 6. (b) Name of husband or wife Nora Mowatt - deceased  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 27, 1892  
 8. AGE: Years 55 Months 3 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Knoxville, Tenn.  
 (Town, county, and state)  
 10. Usual occupation Railroad conductor  
 11. Industry or business \_\_\_\_\_

12. Name Robert Thomas Baker - deceased  
 13. Birthplace Gates City, Wise County, Va.  
 14. Maiden name Frances Bell Naille  
 15. Birthplace Knoxville, Tenn.

16. Informant Hospital Records  
 Address VA Hospital, Perry Point, Md.

17. Removal Aug. 13, 1947  
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
 Cemetery or crematory Unknown

18. Funeral director Pennington & Son  
 Address Bayle de Grace, Md.

19. Aug. 12 19 47 James S. Daugherty  
 (Date noted by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1947 at 9:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 28, 1947 to August 11, 1947  
 and that I last saw him alive on August 11, 1947

Immediate cause of death Pneumonia, bronchial, bilateral DURATION 4-5 days

Due to New growth of the retro-peritoneal lymph nodes, type undetermined  
 Due to Unknown

Other conditions Arteriosclerosis, coronary Unknown

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

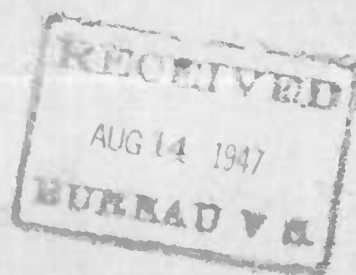
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Medical Examiner \_\_\_\_\_

23. SIGNATURE R. C. DODSON, M.D. Coroner \_\_\_\_\_Address Perry Point, Md. Date signed 8/12-47



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06951

Reg. Dist. No. 96

### 1. PLACE OF DEATH:

County..... Cecil

City or town..... Perry Point  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 6 mos. 17 days

Hospital, institution, or street address where death occurred:

VA Hospital, Perry Point, Md.

How long in hospital or institution? Unknown - was in pvt. sanitarium previous to admission here

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Couoly.....

City or town..... Washington, D.C.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6203 Piney Branch Road  
(If rural, give LOCATION)

2. (a) If veteran, name war..... World War I

### 3. (a) FULL NAME

BELCHES, Frances E.

### 3. (b) Social Security Number

None

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Female

white

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1886

8. AGE: Years..... Months..... Days..... If less than one day.....  
60 9 17 ..... hrs. .... min.

9. Birthplace..... Virginia  
(Town, county, and state)

10. Usual occupation..... Nurse

11. Industry or business.....

12. Name..... Richard Belches - deceased

13. Birthplace..... unknown

14. Maiden name..... Frances Burkley - deceased

15. Birthplace..... Unknown

16. Informant..... Hospital records

Address.....

17. Removal Date thereof..... Aug. 12, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National Cemetery

Location..... Fort Myer, Virginia

18. Funeral director..... PENNINGTON & SON

Address..... Havre de Grace, Md.

19. Aug 12 19 47 James E. Dougherty  
(Date read by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 8 19 47 at 5:05 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 21 19 42 to August 8 19 47

and that I last saw her alive on August 8 19 47

Immediate cause of death..... Embolism, pulmonary  
massive

DURATION

1 hr.

Due to..... Thrombophlebitis, left femoral vein  
36 days

Due to.....

Other conditions..... Ovarian, cystadenoma, right  
(Include pregnancy within 8 months of death) Unknown

Major findings of operations.....

..... Date of op. ....

Autopsy results..... Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... A. E. TROLLINGER M.D. or other

Address..... VAH, Perry Point, Md. Date signed..... 8-11-47

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Good Morning

1 1 65

1. 1000 1000 1000 1000

1000 1000 1000 1000

8 10 1000

RECEIVED  
AUG 14 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

06952

94

## 1. PLACE OF DEATH:

County... North East, Cecil CoCity or town... md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md County... CecilCity or town... North East  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles E Biddle

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Beatrice S Biddle

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 22 18678. AGE: Years Months Days If less than one day  
80 1 1 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace North East Cecil Co Md  
(Town, county, and state)10. Usual occupation Commercial Fisherman

11. Industry or business

12. Name Sarah Biddle13. Birthplace Newark Del14. Maiden name Sarah C Pierce15. Birthplace North East Md16. Informant Beatrice S BiddleAddress North East Md17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Aug 27 1947  
(month) (day) (year)Cemetery or crematory MethodistLocation North East Md18. Funeral director Joseph A GrantAddress North East Md19. 8-27 1947 Lida V Owens  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 - 1947 at \_\_\_\_\_21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 23 1947 to Aug 23 1947and that I last saw him alive on Aug 10 1947Immediate cause of death Cerebral thrombosis DURATION 15 minDue to Cerebral Vascular SenapRenal disease you

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE D A Curren M.D. or otherAddress Aug 25 1947 North East Date signed Aug

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AUG 30 1947  
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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06950

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

### 1. PLACE OF DEATH

County Cecil  
City or town Edgemoor  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 days  
Hospital, institution, or street address where death occurred:  
Union Hospital  
How long in hospital or institution? 20 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Cecil  
City or town Rural Edgemoor  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Oliver L. Balton

### 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1866

8. AGE: Years 80 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cecil, Maryland  
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name George Balton

13. Birthplace Md.

14. Maiden name Bertha Ruby

15. Birthplace Md.

16. Informant Mr. Herman Hartz

Address Rural Edgemoor Md

17. (Burial, cremation, or removal, Which?) Burial Date thereof Aug 13, 1946  
(month) (day) (year)

Cemetery or crematory Edgemoor Cem.

Location Edgemoor Md

18. Funeral director Edward Holloway

Address Millington Md

19. Aug 21 19 46 H. Frazee  
(Date rec'd by registrar) registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 19 46 at 7:20 AM

21. CERTIFY that death occurred on the date above stated; that I attended deceased from September 14, 1946 to Aug 20 19 46

and that I last saw him alive on Aug 19 19 46

Immediate cause of death \_\_\_\_\_

Due to Senility

Due to Fracture hip.

Due to fall

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Anteopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of Dec. 13-1946

Where did injury occur? Edgemoor Cecil Md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury fall - house Injured at work? No

23. SIGNATURE H. Frazee M. D. or other \_\_\_\_\_

Address Cheverly Md Date signed 8/21/46

MARGIN RESERVED FOR BINDING

I

VS 45

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
AUG 25 1947  
BUREAU W B



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

06953

### 1. PLACE OF DEATH:

County CECIL  
City or town PERRY POINT, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 yrs. 1 mo. 13 days  
Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Md.  
How long in hospital or institution? Same as above

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Somerset  
City or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war WW-I

### 3. (a) FULL NAME

BRITTINGHAM, Samuel

### 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) April 30, 1895 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 52 Months 3 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Crisfield, Md.  
(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business \_\_\_\_\_

12. Name Joseph H. Brittingham Deceased  
13. Birthplace Pokomoke, Maryland

14. Maiden name Lillie M. Stevens Deceased  
15. Birthplace Crisfield, Md.

16. Informant Hospital Records  
Address VA Hospital, Perry Point, Md.

17. Burial Date thereof Aug. 4, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Asbury Cemetery  
Location Crisfield, Maryland

18. Funeral director Charles H Ward  
Address Marion Station, Maryland

19. Aug. 1 19 47 J. E. Edgington  
(Date filed by registrar) registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 19 47, at 2:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19, 19 44 to August 1, 19 47  
and that I last saw him alive on August 1, 19 47

Immediate cause of death Pneumonia, bronchial DURATION 6 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions General paralysis of the Insane Unknown  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results Same as above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of \_\_\_\_\_

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

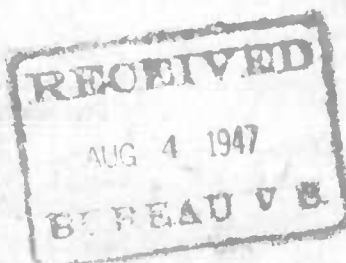
Means of injury -- Injured at work? \_\_\_\_\_

23. SIGNATURE A. E. Trollinger  
A. E. TROLLINGER, M.D., Clinical Director  
Address VAH, Perry Point, Md. Date signed 8-1-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06954

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Leecil  
 City or town Blue Ball North East Pk  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? all time  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County Leecil  
 City or town Blue Ball North East Pk  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Daisy Allie Brown

## 3. (b) Social Security Number

4. Sex F 5. Color or race Col 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Joseph Brown  
 6. (c) If alive, give age 53 years  
 7. Birth date of deceased (mo., day, yr.) Dec. 4 1892

8. AGE: Years 54 Months 7 Days 30 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ellettsville Ind.  
 (Town, county, and state)

10. Usual occupation Wm.

11. Industry or business

12. Name John Morgan  
 13. Birthplace Glasgow Pa.  
 14. Maiden name Margaret Hammond  
 15. Birthplace Hamilton Pa.

16. Informant Alta Brown  
 Address Ellettsville Ind.

17. Burial Date thereof Aug. 7 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill Cemetery  
 Location Cedar Hill Ind.

18. Funeral director Edw. H. Bell  
 Address 907 Poplar St. N. W. Wash.

19. Aug 7 1947 J. H. Frazer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1947 at 3:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death CoronaryDue to myocarditis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

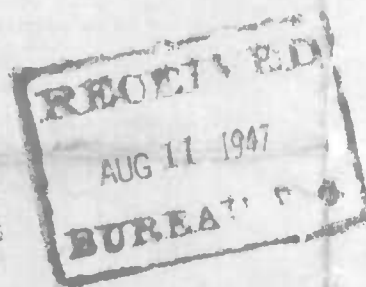
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. H. Dodson Medical ExaminerAddress Ellettsville Ind. M. D. or other \_\_\_\_\_Date signed 8-3-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06955

## CERTIFICATE OF DEATH

Reg. Dist. No. 9C

## 1. PLACE OF DEATH:

County Cecil  
City or town Calvert  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 mo.

Hospital, institution, or street address where death occurred:

Mayfield HospitalHow long in hospital or institution? 2 mo.

## 3. (a) FULL NAME

Ida May Cooper

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

James Cooper (dec.)

7. Birth date of deceased (mo., day, yr.)

2/24/1864

8. AGE:

Years

Months

Days

If less than one day

8364

hrs.

min.

9. Birthplace

Cecil Co. Md.  
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

J. Washington Alexander

12. Name

Cecil Co.

13. Birthplace

Elizabeth Benjamin

14. Maiden name

Cecil Co. Md.

15. Birthplace

Mrs. Ella Harris

16. Informant

67 Martins Lane, Yardville N.J.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

8/9/47  
(month) (day) (year)

Cemetery or crematory

Angel Hill

Location

Harold's Branch

18. Funeral director

Perumpan & Son

Address

Harold's Branch, Md.

19. Aug 9 1947

(Date paid by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Calvert  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8-6 19 47 at 6:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 19 47, to Aug 6 19 47and that I last saw him alive on Aug 4 19 47

Immediate cause of death

Cerebrovascular  
Accident

Due to

Chronic myocarditis  
& hypertension

Due to

Other conditions Slight stroke 3 months  
B.P.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

J. Michael H. M.D.  
M. D. or other \_\_\_\_\_  
Address Perumpan & Son Date signed 8-6-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 12 1947  
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06956

Reg. Dist. No. 8 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Port Deposit Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? About 5 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Pennsylvania County Lancaster  
 City or town Columbia  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Eleanor S. Craig

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife  
 6. (c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) August 6, 1874  
 8. AGE: Years 73 Months 0 Days 23 If less than one day hrs. min.

9. Birthplace Columbia, Lancaster Co., Pa.  
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Dr. Alexander Craig  
 13. Birthplace Westmoreland Co., Pa.

MOTHER 14. Maiden name Eleanor M. Righter  
 15. Birthplace Lancaster Co., Pa.

16. Informant Florence B. Craig  
 Address Port Deposit, Md. Rural

17. Cremation Date thereof Sept. 1, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Green Mount  
 Location Baltimore, Md.

18. Funeral director Wm. A. Patterson & Son  
 Address Perryville, Md.

19. Aug. 30, 1947 James S. Daugherty  
 (Date signed by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 29<sup>th</sup>, 1947 at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 27, 1946 to August 3, 1947 and that I last saw her alive on August 26, 1947

Immediate cause of death Chronic Valvular Heart Disease DURATION 5 yrs

Due to

Due to

Other conditions Hypertension 10 yrs  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. F. Magraw M. D. or other  
 Address Perryville, Md. Date signed 8/30/47



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SEP 2 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

158

06957

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County... Cecil

City or town... Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hours

Hospital, institution, or street address where death occurred:

102 Hollings Wood Manor

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Cecil

City or town... Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

John Ellwood

## 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Single

6.(b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.)

August 7, 1947

8. AGE: Years Months Days It less than one day

12 hrs. 5 min.

9. Birthplace

Elkton, Md

(Town, county and state)

10. Usual occupation .....

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug 9, 1947

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Aug 9, 1947

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1947 at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 7, 1947 to August 7, 1947

and that I last saw him alive on August 7, 1947

Immediate cause of death

Cardiac Failure

## DURATION

1 day

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? .....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Mesns of injury

Injured at work?

23. SIGNATURE

Address

Date signed

CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

06958

### 1. PLACE OF DEATH:

County Ind  
City or town Chesapeake City Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Ind County Calhoun  
City or town Chesapeake City Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Anna L. GONCE

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widow

### 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 23 1963

8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ind  
(Town, county, and state)

10. Usual occupation House work

11. Industry or business

12. Name John T. Wilson

13. Birthplace Ind.

14. Maiden name Emily E. Woodland

15. Birthplace Ind.

16. Informant Louara Williams

Address Chesapeake City Md.

17. Date thereof Aug 31 1947  
(month) (day) (year)

18. Cemetery or crematory Johnston Cemetery

Location near Bayville Md

19. Funeral director Johnston

Address Townsend Del.

20. Date of death August 31 1947

21. Signature Anna B. G. G. G.

22. Address Chesapeake City Md

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 19 47 at 905 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 19 47 to Aug 29 19 47

and that I last saw h. W alive on Aug 29 19 47

Immediate cause of death Carcinoma of breast (left) DURATION 3 years

Carcinoma of face 4 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations None

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Thos Davis MD

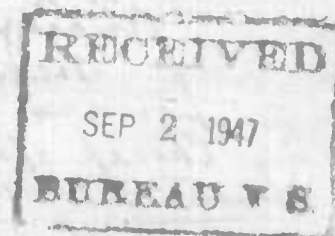
Address Chesapeake City Md

Date signed 8/30/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contact age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

HH 110. G 112 SEP 8 1947

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

06959

### 1. PLACE OF DEATH

County Cecil  
City or town Elkton Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 weeks  
Hospital, institution, or street address where death occurred:  
Univ. Hospital, Elkton, Md.  
How long in hospital or institution? 3 weeks

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Cecil  
City or town Elkton Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 201 East High St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Clara Bertha Gordon

### 3. (b) Social Security Number

4. Sex Female 5. Color or race colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife none

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1872 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 75 Months 7 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Elkton Md.  
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name George Gordon

13. Birthplace Elkton Md.

14. Maiden name Sarah McCabe

15. Birthplace Elkton Md.

16. Informant Matilda Boardly

Address 119 Booth St, Elkton, Md.

17. Funeral Date thereof Aug 25, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Providence Cemetery

Location Elkton Md.

18. Funeral director Carroll Bell

Address 909 Poplar St. N. B. Rd.

Aug 25 19 47 F. J. Frazer  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 19 47 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22 19 47, to August 22 19 47, and that I last saw him/her alive on August 22 19 47.

Immediate cause of death Cerebral hemorrhage DURATION 3 weeks

Due to Arteriosclerosis, hypertension, Cardio-vascular disease

Due to

Other conditions Acute paratyphoid, right, Cause undetermined 1 week  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

S. Ralph Andrews, Jr.

23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_

Address 233 E. Main St., Elkton Date signed 8/23/47

md

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AUG 27 1947

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

06960

## 1. PLACE OF DEATH

County..... Cecil  
 City or town..... Pk 213 Williams St  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Cecil

City or town..... Elkton  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 408 North St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Irvin Hadaway.

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Virginia Hadaway.

## 7. Birth date of

deceased (mo., day, yr.)

Dec. 4 1901

5.(c) If alive, give age. 45 years

## 8. AGE:

Years

Months

Days

If less than one day

45

8

19

hrs.

min.

## 9. Birthplace

Edesville Md.

(Town, county, and state)

## 10. Usual occupation

Sea Captain

## 11. Industry or business

FATHER  
 MOTHER

## 12. Name

Henry Clay Hadaway

## 13. Birthplace

Rock Hall Md.

## 14. Maiden name

Lillian Walcott

## 15. Birthplace

Rock Hall Md

## 16. Informant

Virginia Hadaway

## Address

408 North St Elkton Md

## 17.

(Burial, cremation, or removal, Which?)

## Date thereof.

Aug 27 47

## Cemetery or crematory

Elkton

## Location

Elkton Md

## 18. Funeral director

H. W. Pippin

## Address

Elkton Md

## 19.

Aug 25 19 47

J. H. Frazer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 19 47 at 7:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Ciguatera  
 secondary  
 disease.

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. L. Dodson  
 Elkton Md  
 Address: Elkton Md Date signed: 8-25-47

Medical Examiner

Cecil County

M. D. or other

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06964

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil  
County.....  
City or town..... Elkton, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
Union Hospital  
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Md. County..... Cecil  
City or town..... Elkton  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... Howard  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME Mary Hartnett  
3. (b) Social Security Number

4. Sex F. 5. Color or race Wh. 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) October 3, 1873 6. (c) If alive, give age..... years

8. AGE: Years 73 Months 10 Days 11 If less than one day..... hrs. .... min.

9. Birthplace Elkton, Md.  
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Michael Hartnett

13. Birthplace Ireland

14. Maiden name Hannah Carter

15. Birthplace Ireland

16. Informant Miss Hannah Hartnett

Address Howard St. Elkton, Md.

17. Burial Date thereof Aug 18, 1947

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Catholic

Location Elkton, Md.

18. Funeral director Rev. P. P. P.

Address Elkton, Md.

19. Aug 18, 1947 J. R. Fraser

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14, 1947 at 5:37 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11, 1947, to Aug 14, 1947,

and that I last saw him alive on Aug 14, 1947.

Immediate cause of death Cerebral Hemorrhage

Due to Apoplexy -

Due to Fracture of Hip

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Aug 11/47

Where did injury occur? same - Elkton, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Fall

Means of Injury Fall Injured at work?

23. SIGNATURE J. R. Fraser

Address Water Court St. Date signed Aug 13/47

Regist. Dist. No. 92

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06961

96

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... **Cecil**  
 City or town..... **Perry Point, Maryland**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **7 months, 29 days**  
 Hospital, institution, or street address where death occurred:  
**V.A.H., Perry Point, Md.**  
 How long in hospital or institution? **7 months, 29 days**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... **Maryland** County..... **Baltimore**  
 City or town..... **Baltimore**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... **225 E. Heath Street**  
 (If rural, give LOCATION)  
**World War II**  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**John Leonard HOFFMAN Jr.**

## 3. (b) Social Security Number

4. Sex..... **Male**  
 5. Color or race..... **White**  
 6.(a) Single, married, widowed, or divorced..... **Single**  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... **7-15-26**  
 8. AGE: Years..... **21** Months..... **1** Days..... **10**  
 If less than one day..... hrs. .... min.

9. Birthplace..... **Baltimore, Maryland**  
 (Town, county, and state)  
 10. Usual occupation..... **Unknown**  
 11. Industry or business..... **Unknown**  
 12. Name..... **John Leonard Hoffman Sr.**  
 13. Birthplace..... **Baltimore, Maryland**  
 14. Maiden name..... **Mary Madkins**  
 15. Birthplace..... **Cambridge, Maryland**

16. Informant **Father and Hospital Records**Address **1510 Battery Ave., Balto., Md.**17. **Reburial** Date thereof..... **Aug 26, 1947**  
 (Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory..... **Cedar Hill**Location..... **Baltimore, Md.**18. Funeral director..... **Joe McCully**Address **130 E. Federal, Baltimore 31**19. **Aug 26** 19. **47** **Gene E. Daugherty**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **August 25, 1947** 19..... at **4:25 P. M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19....., 10....., 19.....  
 and that I last saw him..... alive on..... 19.....

Immediate cause of death..... **Drowning**

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results..... **No abnormalities found**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... **Suicide** Date of..... **Aug. 25, '47**Where did injury occur? **V.A.H., Perry Point, Md.**  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... **John Leonard Hoffman Jr.** Medical ExaminerAddress..... **Baltimore, Md.** 101 Cecil CountyDate signed..... **8/25-47** M. D. or other

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06962

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County... Cecil  
 City or town... Rural near Elkton, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 1/2  
 Hospital, institution, or street address where death occurred:  
 Elkton R.D.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Md. County... Cecil  
 City or town... Rural near Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Elkton R.D.  
 (If rural, give LOCATION)  
 2.(c) If veteran, name war

## 3. (a) FULL NAME

Mabel Holmes

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

F. Wh. Single

8. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1924

8. AGE: Years 23 Months 6 Days 0  
 If less than one day hrs. min.

9. Birthplace Elkton, Md.  
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Green Holmes

13. Birthplace Elkton R.D. Md.

14. Maiden name Corrie Rothwell

15. Birthplace Elkton, Md.

16. Informant Mrs Corrie Holmes

Address Elkton R.D. Md.

17. Burial Date thereof Aug 22/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Md.

18. Funeral director H. W. Lippin

Address Elkton, Md.

Aug 21, 1947 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1947 at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 1940 to Aug 19 1947

and that I last saw him alive on Aug 19 1947

Immediate cause of death

Pulmonary T.B. DURATION about 7 1/2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. of other

Address

Date signed

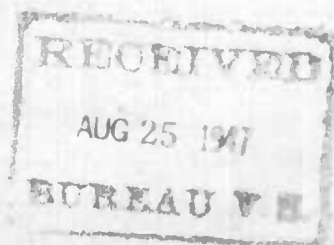
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VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# STATE OF MARYLAND—CERTIFICATE OF DEATH 06963

## 1. PLACE OF DEATH

County

Village or City

No.

Registration Dist. No.

St.

Ward

Length of residence in city or town where death occurred

75 yrs.

6 mos.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

How long in U.S. if of foreign birth? yrs. mos. ds.

## 2. FULL NAME

If U.S. Veteran specify WAR

(a) Residence: No.

(Usual place of abode)

St.

Ward.

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, end year)

7. AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month end year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

MOTHER FATHER

13. NAME

14. BIRTHPLACE (city or town) (State or country)

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT (Address)

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

19. UNDERTAKER (Address)

20. FILED

19 47

## MEDICAL CERTIFICATE OF DEATH

### 21. DATE OF DEATH

August 24- 1947

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY. That I attended deceased from February 24, 1947, to Aug 24, 1947

I last saw him alive on Aug 23, 1947; death is said to have occurred on the date stated above, at 7.00 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Acute Lymphatic Leukemia

Date of onset

8 mos

Other Contributory Causes of importance:

none

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of Injury

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

|                                       | Date of onset       |
|---------------------------------------|---------------------|
| <i>Arteriosclerosis</i>               | <i>1915</i>         |
| <i>Chronic interstitial nephritis</i> | <i>1921</i>         |
| <i>Cerebral hemorrhage</i>            | <i>July 5, 1927</i> |

Other contributory causes of importance:

|                   |                    |
|-------------------|--------------------|
| <i>Gallstones</i> | <i>May 1, 1923</i> |
|-------------------|--------------------|

## Example II

The principal cause of death and related causes of importance were as follows:

|                               | Date of onset     |
|-------------------------------|-------------------|
| <i>Attack of epilepsy</i>     | <i>1 week ago</i> |
| <i>Run over by street car</i> | <i>1 week ago</i> |
| <i>Peritonitis</i>            | <i>3 days ago</i> |

Other contributory causes of importance:

|                        |               |
|------------------------|---------------|
| <i>Gastroenteritis</i> | <i>1 year</i> |
|------------------------|---------------|

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 95

06965

## 1. PLACE OF DEATH:

County... Cecil  
 City or town... Rising Sun  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 70 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Cecil  
 City or town... Rising Sun  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

J. Otis Kennard

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Anna Kennard

## 7. Birth date of deceased (mo., day, yr.)

Feb. 11, 1870

## 6. (c) If alive, give age

70 years

## 8. AGE:

Years

Months

Days

If less than one day

77

6

14

hrs.

min.

## 9. Birthplace

Colona Md.  
(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

FATHER

MOTHER

## 12. Name

Jacob Kennard

## 13. Birthplace

Paradise, Pa.

## 14. Maiden name

Hannah Griffith

## 15. Birthplace

Liberty Grove, Md.

## 16. Informant

Mrs Anna Kennard

## Address

Rising Sun, Md.

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

Aug. 28, 1947  
(month) (day) (year)

## Cemetery or crematory

West Nottingham

## Location

Colona Md.

## 18. Funeral director

J. E. Tyson

## Address

Rising Sun, Md.

## 19.

(If not, I'd by registrar)

19

Aug 26 - 47 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25, 1947, at 1.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1, 1947, to Aug 25, 1947

and that I last saw him alive on Aug 20, 1947

Immediate cause of death

Acute coronary disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. D. Doolson M.D.  
Rising Sun, Md. Date signed Aug 26 - 47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15N

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 28 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Perry Point, Maryland  
 (If outside city or town limits, write nearest town and give nearest town)  
 How long in above place of death? 9 yrs. 1 mo. 25 days  
 Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Md.  
 How long in hospital or institution? Since July 8, 1937

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State New York County \_\_\_\_\_  
 City or town Rockville Center  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 59 Princeton Avenue  
 (If rural, give LOCATION)  
 2(a) If veteran, name war WWI

## 3. (a) FULL NAME

McARTHUR, James H.

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Unknown  
 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1873

8. AGE: Years 73 Months 7 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Elgin, Ill.  
 (Town, county, and state)

10. Usual occupation Clergyman

11. Industry or business \_\_\_\_\_

12. Name James M. Carthur - deceased

13. Birthplace Illinois

14. Maiden name Eliza Jane McArthur - deceased

15. Birthplace Unknown

16. Informant Hospital Records

Address \_\_\_\_\_

17. Removal Date thereof Aug 5, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director PENNINGTON & SON

Address Bayre de Grace, Md.

19. Aug 5 19 47 June E. Dargatzis  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1947 11:05 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 7, 1938 to August 2, 1947  
 and that I last saw him alive on August 2, 1947

Immediate cause of death \_\_\_\_\_ DURATION  
Acute massive collapse, left lung 10 days  
Pleurisy, sero-fibrinous, with effu- 2-3 weeks  
Pneumonia, bronchial, right 1 week  
Ileus paralyticus 24 hrs.

Other conditions Arteriosclerosis, general-  
ized Unknown  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results Same as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. E. TROLLINGER M. D. or other  
VAH Perry Point, Md. Clinical Director  
 Address \_\_\_\_\_ Date signed 8-4-47

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AUG 6 1947

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5



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

8

06967

## CERTIFICATE OF DEATH

Reg. Dist. No. \_\_\_\_\_

### 1. PLACE OF DEATH:

County Cecil  
City or town near Cecil  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: \_\_\_\_\_

Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_

Stay in this community (yrs., or mos., or days) \_\_\_\_\_

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County \_\_\_\_\_  
City or town Phila  
(If outside city or town limits, write RURAL NEAR and give town)  
Ward No. \_\_\_\_\_

Street No. \_\_\_\_\_  
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

Wrie A. Newnom

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed

B (b) Name of husband or wife \_\_\_\_\_

B (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) June, 2nd 1892

8. AGE: Years 75 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Del  
(Town, county, and state)

10. Usual occupation retired chief engineer

11. Industry or business \_\_\_\_\_

12. Name Nathaniel Newnom  
13. Birthplace Bethel, Mullington, Md.

14. Maiden name Eliza Jane Dehmer  
15. Birthplace Del

16. Informant Mrs. Robert Austin  
Address Cecilton, Md.

17. Burial Date thereof 8/17/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Bethel Cemetery  
Location near Chesapeake City Md

18. Funeral director G. Foster Tansil  
Address 1706 N. and Del.

19. Aug 17 19 47 Mrs. Harold W. Clugney  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 47 at 6:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Death 19 37 to Aug 14 19 47  
and that I last saw him alive on August 14 19 47

Immediate cause of death Arteriosclerosis

Due to Chronic hypertension  
Due to Coronary artery disease

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Thos J. Dorro MD  
Address Chesapeake City Md Date signed 8/17/47  
M. D. or other \_\_\_\_\_

DURATION

4 days

10 years

PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 19 1947

BUREAU F S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06968

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County..... **CECIL**  
 City or town..... **Perry Point, Maryland**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **8 yrs. 6 mos. 29 das.**  
 Hospital, institution, or street address where death occurred:  
**VAH, Perry Point, Maryland**  
 How long in hospital or institution? **12 years**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... **Maryland** County..... **Baltimore**  
 City or town..... **Baltimore**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **3211 Elmley Ave.,**  
 (If rural, give LOCATION)  
**World War I**  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**JERE NACE NICHOLS**

## 3. (b) Social Security Number

**Unknown**

4. Sex..... **Male** 5. Color or race..... **White** 6.(a) Single, married, widowed, or divorced..... **Widowed**  
 6.(b) Name of husband or wife..... **Anna Pletzer Nichols -**  
**Deceased** 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) **April 3, 1898**  
 8. AGE: Years..... **49** Months..... **4** Days..... **7** If less than one day..... hrs. .... min.

9. Birthplace..... **Baltimore, Maryland**  
 (Town, county, and state)  
 10. Usual occupation..... **Laborer**  
 11. Industry or business.....

**FATHER**  
 12. Name..... **Unknown**  
 13. Birthplace..... **Unknown**  
**MOTHER**  
 14. Maiden name..... **Unknown**  
 15. Birthplace..... **Unknown**

16. Informant..... **Hospital Records**  
 Address..... **VAH, Perry Point, Md.**  
 17. **Removal** Date thereof **Aug 13, 1947**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... **Baltimore National Cemetery**  
 Location..... **Baltimore, Maryland**  
**E. Willis Lamoreau S.L.**  
 18. Funeral director..... **E. WILLIS LAMOREAU**  
 Address..... **4510 Liberty Heights Ave., Balto., Md.**

19. **Aug. 11, 1947** **Irene E. Laughlin**  
 (Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **August 10** 19 **47** at **5:25 P.M.**  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**January 11** 19 **39** to **August 10** 19 **47**  
 and that I last saw him alive on **August 10, 1947** 19

Immediate cause of death..... **Tuberculosis, pulmonary, far advanced,**  
**chronic, active** DURATION..... **Since 1922**

Due to.....  
 Due to.....

Other conditions..... **Psychosis-intoxication, Korsakow's** **Unknown**  
 (Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....  
 Autopsy results..... **Same as above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work? .....

23. SIGNATURE..... **A. E. TROLLINGER** **M.D., Clinical Director**  
 Address..... **VAH, Perry Point, Md.** Date signed **8-11-47**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH:</b><br>County..... <u>Arl</u><br>City or town..... <u>Albion</u><br><small>(If outside city or town limits, write RURAL and give nearest town)</small><br>How long in above place of death?..... <u>4 mo.</u><br>Hospital, institution, or street address where death occurred:<br><u>Maryland Nursing Home</u><br>How long in hospital or institution?..... <u>4 mo.</u> |  |   |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b><br><small>(For newborn infants give residence of mother)</small><br>State..... <u>Md</u> County..... <u>Cecil</u><br>City or town..... <u>Chesapeake City</u><br><small>(If outside city or town limits, write RURAL and give nearest town)</small><br>Street No..... <u>Md</u><br><small>(If rural, give LOCATION)</small><br>2.(a) If veteran, name war..... |  |  |  |
| <b>3. (a) FULL NAME</b><br><u>Della May Peterson</u>  |  |   |  | <b>3. (b) Social Security Number</b><br><br>   |  |  |  |
| <b>4. Sex</b><br><u>F.</u>  |  | <b>5. Color or race</b><br><u>Wh.</u>     |  | <b>6. (a) Single, married, widowed, or divorced</b><br><u>Married</u>  |  |  |  |
| <b>6. (b) Name of husband or wife</b><br><u>George Peterson</u>   |  |   |  | <b>6. (c) If alive, give age</b> ..... years   |  |  |  |
| <b>7. Birth date of deceased (mo., day, yr.)</b><br><u>May 22, 1869</u>   |  |   |  |  |  |  |  |
| <b>8. AGE:</b> Years <u>78</u> Months <u>3</u> Days <u>1</u>  |  | It less than one day ..... hrs. .... min. |  |  |  |  |  |
| <b>9. Birthplace</b><br><u>Chesterton, Ind.</u><br><small>(Town, county, and state)</small>   |  |   |  |  |  |  |  |
| <b>10. Usual occupation</b><br><u>at home</u>   |  |   |  |  |  |  |  |
| <b>11. Industry or business</b><br><br>   |  |   |  |  |  |  |  |
| MOTHER FATHER   | <b>12. Name</b><br><u>George H. (over)</u> |   |  |  |  |  |  |
|   | <b>13. Birthplace</b><br><u>Maryland</u>   |   |  |  |  |  |  |
|   | <b>14. Maiden name</b><br><u>Unknown</u>   |   |  |  |  |  |  |
|   | <b>15. Birthplace</b><br><br>              |   |  |  |  |  |  |
| <b>16. Informant</b><br><u>Welfare Office</u><br>Address <u>Elkton, Md.</u>   |  |   |  |  |  |  |  |
| <b>17. Burial</b><br><small>(Burial, cremation, or removal. Which?)</small> Date thereof <u>Aug 26 / 47</u><br><small>(month) (day) (year)</small><br>Cemetery or crematory <u>Bethel</u><br><u>Near Chesapeake City, Md</u><br>Location <u>1st St &amp; Poplar</u>   |  |   |  |  |  |  |  |
| <b>18. Funeral director</b><br><u>Elkton, Md</u><br>Address   |  |   |  |  |  |  |  |
| <b>19. Aug 25 19 47</b><br><small>(Date rec'd by registrar)</small> Registrar <u>J.R. Buzar</u>   |  |   |  |  |  |  |  |

**MEDICAL CERTIFICATION**

20. DATE OF DEATH..... 8 - 23 ....., 19 47, at 1:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 47, to Aug 23 19 47 and that I last saw him/her alive on 8-22 19 47

| Immediate cause of death                                    | DURATION |
|---|----------|
| Pulmonary Embolism  |          |
| Senility & Hypertension                                     |          |
| Cardiovascular Disease                                      |          |
| (Vascular Thrombosis for)                                   |          |
| Bad Luck  |          |
| Other conditions: old fracture left upper femur.            |          |
| <small>(Include pregnancy within 3 months of death)</small> |          |

Major findings of operations.....  
 Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

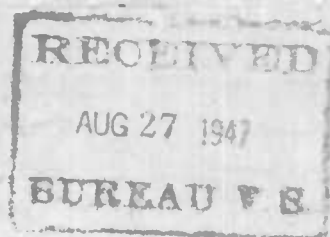
Accident, suicide, or homicide..... Date of.....

Where did injury occur? .....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work?

23. SIGNATURE..... G.M. Wilkins, M.D.  
M. D. or other  
 Address Rt. 1, Elkton, Md. Date signed 8-23-47

According to Mr Peterson, Mrs Peterson was taken at the age of four by Mr and Mrs George E. Hurtt but was never legally adopted by them. He thinks Mrs Peterson's father's name was Greenfield.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170 C

06970

## CERTIFICATE OF DEATH

Reg. Diat. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Charleston, Route 4  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Cecil  
 City or town Hardegrave  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Olga Brooke Phinezy

## 3. (b) Social Security Number

4. Sex F. 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife William S. Phinezy

7. Birth date of deceased (mo., day, yr.) Sept 5, 1897  
 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 49 Months 11 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Yokima County, Washington  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name No Record

13. Birthplace \_\_\_\_\_

14. Maiden name Mrs. Mary Adams15. Birthplace State of Washington16. Informant Mrs. Gladys PetrieAddress 1811 Pine St Fort Wayne Ind.17. Removal Date thereof 8-21-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Renton, WashingtonLocation Near Tacoma Washington18. Funeral director Elmer E. BullardAddress 556 Lewis St. New de G...19. Aug 19 19 47 Irma E. Longm...

(Date recd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 19 47 at 9:53 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

Fractured neck.Fracture of Rt. femur.Due to fore arm. Rt. femur.Laceration of chinDue to & scalp.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8-12-47Where did injury occur Charleston Cecil Ind. (City or town) (County) (State)Injured at home, farm, industry, public place (where) Route 40Means of injury auto. Injured at work? noMedical Examiner R. E. Dodson for Cecil County23. SIGNATURE R. E. Dodson M. D. or otherAddress Keams Sun Ind. Date signed 8/12-47





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06971

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH

County... Cecil  
 City or town... Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 days  
 Hospital, institution or street address where death occurred:  
 155 E. Main Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Md. County... Cecil  
 City or town... Principio Furnace  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... R.F.D.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... not a veteran

## 3. (a) FULL NAME

William B. Reed

## 3. (b) Social Security Number

4. Sex... Male  
 5. Color or race... White  
 6.(a) Single, married, widowed, or divorced... Widowed  
 6.(b) Name of husband or wife... Fanny May Reed  
 6.(c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.)... March 20 1870  
 8. AGE: Years... 77 Months... 4 Days... — If less than one day... hrs. ... min.

9. Birthplace... Bayview Cecil Md.  
 (Town, county, and state)  
 10. Usual occupation... Blacksmith  
 11. Industry or business

12. Name... Unknown  
 13. Birthplace... Unknown  
 14. Maiden name... Unknown  
 15. Birthplace... Unknown

16. Informant... Mrs. Mary C. Henry  
 Address... 155 E Main St.

17. Burial... Date thereof... Aug. 19 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory... Principio Methodist  
 Location... Principio Furnace  
 18. Funeral director... Joseph R. Lewis  
 Address... North East Md.

19. Aug 18 1947... J.H. Frazer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 16 August 1947, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 August 1947, to 16 Aug 1947, and that I last saw him alive on 16 August 1947.

Immediate cause of death... Coronary thrombosis DURATION

Due to... Hypertensive Cardiovascular Disease  
 Due to... Arteriosclerosis

Other conditions... Apoplexy with facial and laryngeal paralysis  
 (Include pregnancy within 3 months of death)

Major findings of operations... None

Autopsy results... None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE... George Kneis, Jr. M.D.  
 Address... Elkton Md. M.D. or other  
 Date signed... 16 Aug 47

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 20 1947  
BUREAU # 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06972

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH

County Cecil  
 City or town Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 minutes  
 Hospital, institution, or street address where death occurred:  
Union Hospital, Elkton, Md.  
 How long in hospital or institution? 15 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil  
 City or town Rising Sun  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1 mi. East of Rising Sun  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

John Henry Robinson

## 3. (b) Social Security Number

164-10-6415

4. Sex 5. Color of race 6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Amy Robinson7. Birth date of deceased (mo., day, yr.) Nov. 23, 1899

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
47 8 19 hrs. min.9. Birthplace Hughesville, Pa.  
(Town, county, and state)10. Usual occupation Miller11. Industry or business Electricity manufacturers12. Name John Robinson13. Birthplace Penn.14. Maiden name Emma Fineweaver15. Birthplace Penn.18. Informant Amy RobinsonAddress Rising Sun, Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-15-1947  
(month) (day) (year)Cemetery or crematory Friends CemeteryLocation Calvert, Md.18. Funeral director Ralph M. ReedAddress Rising Sun, Md.19. Aug 14 19 47 FR Frazier  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 19 47 at 8:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

acute coronary disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. L. Doctorson Medical ExaminerAddress Rising Sun, Md. for Cecil CountyDate signed 8/13-47

RECEIVED  
AUG 18 1947  
BUREAU # 8

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06973

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 mos  
Hospital, institution, or street address where death occurred:  
Union Hosp.  
How long in hospital or institution? 7 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
Maryland Cecil  
State..... County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
Earl S. Rutter

3. (b) Social Security Number

4. Sex Male  
5. Color or race white  
6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug 17-1907  
6. (c) If alive, give age..... years

8. AGE: Years 46 Months 1 Days 27 hrs. .... min.

9. Birthplace Perryville - Md  
(Town, county, and state)

10. Usual occupation Railroad laborer

11. Industry or business

12. Name Harry S. Rutter

13. Birthplace Cecil Co - Md

14. Maiden name Bertha Mae Dougherty

15. Birthplace Elk Mills - Md

16. Informant Mrs Harry S. Rutter - mother

Address Perryville - Md

17. Burial Date thereof Aug 11, 1949  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Auburn

Location Perryville, Md

18. Funeral director L. A. Patterson & Son

Address Perryville, Md

19. Aug 90 19 47 IR Frazer

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 8th 1947 at 1:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6th 1947 to Aug 8 - 1947  
and that I last saw him alive on Aug 80 1947

Immediate cause of death Infection - generalized infectious  
Diphtheria due to L. diphtheriae  
Due to Hemolytic St. Ph. L. aureus

Other conditions bed contracture of joints  
result of prolonged bed rest.  
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature W. A. McSpigott M.D.

Address Eexton, Md. Date signed 8/9/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 12 1947  
BUREAU V. E.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06974

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Perry Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 3 mos. 5 days  
 Hospital, institution, or street address where death occurred:  
VA Hospital, Perry Point, Md.  
 How long in hospital or institution?..... 6 mos. 14 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D.C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. .... 609 G. Street, S.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... WW-I

## 3. (a) FULL NAME

SCHNAEBELE, Theodore

## 3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... Married  
 6.(b) Name of husband or wife..... Alice M. Haskinson  
 6.(c) If alive, give age..... 49 years  
 7. Birth date of deceased (mo., day, yr.)  
 8. AGE: Years..... 57 Months..... 7 Days..... 0 If less than one day..... hrs. .... min.

9. Birthplace..... Washington, D.C.  
 (Town, county, and state)  
 10. Usual occupation..... Unknown  
 11. Industry or business  
 12. Name..... Frederick Jacob Schraebele-deceased  
 13. Birthplace..... Baden, Germany  
 14. Maiden name..... Elizabeth Heuser - deceased  
 15. Birthplace..... Elben, Germany

16. Informant..... Hospital Records  
 Address..... VA Hospital, Perry Point, Md.  
 17. Removal Date thereof..... Aug. 5, 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory..... Unknown  
 Location..... Washington, D.C.

18. Funeral director..... PENNINGTON & SON  
 Address..... Bayre de Grace, Md.

19. Aug. 5 19 47 Irma E. Langhans  
 (Date registered by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 4, 19 47 at 11:10 A  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 29, 19 47 to August 4, 19 47  
 and that I last saw him alive on August 4, 19 47

Immediate cause of death..... Thrombosis, cerebral DURATION..... sudden  
 Due to..... Hemiplegia, left 7 mos.  
 Due to..... Arteriosclerosis, cerebral 7 mos.

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE..... A. E. TROLLINGER, M.D., Clinical Director  
 Address..... VAH, Perry Point, Md. Date signed..... Aug 5 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 6 1947  
BUREAU a

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46d

66975

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

### 1. PLACE OF DEATH:

County... Cecil  
City or town... Elkton, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
Hospital, institution, or street address where death occurred:  
Union Hosp. - Elkton, Maryland

How long in hospital or institution? 27 July '47 to 6 Aug '47

### 3. (a) FULL NAME

Charles F. Smith

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Edna Mae Wheatman (deceased)

7. Birth date of deceased (mo., day, yr.) June 4 1887 6. (c) If alive, give age years

8. AGE: Years 60 Months Days If less than one day hrs. min.

9. Birthplace Hoboken, New Jersey (Town, county, and state)

10. Usual occupation Furniture Repairman

11. Industry or business Own Upholstery Shop

12. Name Otto Schmidt

13. Birthplace Germany

14. Maiden name Emma V. Mahce

15. Birthplace Illinois

16. Informant Deceased

Address R.D. #4 Elkton, Maryland

17. Burial Date thereof Aug 11 - 47 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Methodist

Location North East Md

18. Funeral director Joseph R. Shant

Address North East Md

19. Aug 11 19 47 JH Frazer (Date rec'd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Rural - Elkton (If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #4 (If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (b) Social Security Number

D

### MEDICAL CERTIFICATION

D.S.T.

20. DATE OF DEATH 6 August 19 47 at 8:48 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 47 to 6 August 19 47

and that I last saw him alive on 6 August 19 47

Immediate cause of death Peritonitis, acute

DURATION

3 days

Due to Adenocarcinoma of the recto-sigmoid colon 1 year

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Adenocarcinoma of the recto-sigmoid

Date of op. 30 July 47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Klaus H. Huebner M.D. M.D. or other

Address North East, Md Date signed 6 Aug 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 12 1947  
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

66976

91

1. PLACE OF DEATH: Cecil  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 Cecil Ave.  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland..... County..... Cecil.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
 Edward H. Walker.

3. (b) Social Security Number

4. Sex..... Male.....  
 5. Color or race..... white.....  
 6. (a) Single, married, widowed, or divorced..... married.....  
 6. (b) Name of husband or wife..... Florence Walker.....  
 6. (c) If alive, give age..... years.....  
 7. Birth date of deceased (mo., day, yr.)..... Apr 19, 1864.....  
 8. AGE: Years..... 83..... Months..... 3..... Days..... 12.....  
 If less than one day..... hrs..... min.....

9. Birthplace..... Cecil Co. Maryland.....  
 (Town, county, and state)

10. Usual occupation..... Boat yard worker.....

11. Industry or business.....

12. Name..... James Walker.....

13. Birthplace..... Maryland.....

14. Maiden name..... Mary Haggitt.....

15. Birthplace..... Maryland.....

16. Informant..... Mother.....

Address..... Chesapeake City, Md.....

17. Burial..... Date thereof..... Aug 3/47.....  
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory..... Bethel.....

Location..... near Chesapeake City, Md.....

18. Funeral director..... H. W. Pippin.....

Address..... Elkton, Md.....

19. August 2nd 1947..... Registrar.....

(Date rec'd by registrar).....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug 1..... 1947.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....

Address.....

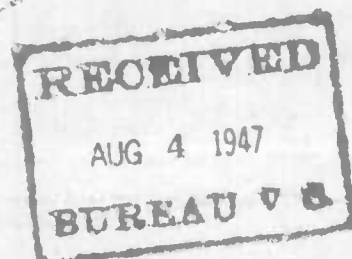
Date signed.....

Medical Examiner.....

M. D. or other.....

Address.....

Date signed.....







RECEIVED

AUG 25 1947

BUREAU F B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

06978

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil  
 City or town Elkton Rural  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Sylvester Wesley

## 3. (b) Social Security Number

4. Sex

M.

5. Color or race

Coe

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife:

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Aug 2 - 1947

8. AGE:

Years

Months

Days

If less than one day

5 hrs. min.

9. Birthplace

Elkton MD Md.  
(Town, county, and state)

10. Usual occupation

Child

11. Industry or business

MOTHER FATHER

12. Name

Charles Albert Wesley

13. Birthplace

Elkton Md.

14. Maiden name

Gertrude M Conigo

15. Birthplace

Elkton Md.

16. Informant

Address

Gertrude M Wesley  
Elkton MD - Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Aug 5 - 47  
(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

Elkton Rural

18. Funeral director

Address

Joseph R. Grant  
North East, Md.

19.

(Date rec'd by registrar)

Aug 4 19 47H. Frazier  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Md. Cecil  
Elkton R.D. 4  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 2 19 47, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

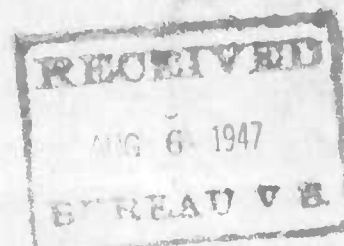
Means of injury

Injured at work?

23. SIGNATURE

Address

W. D. Jackson  
Elkton R.D. 4  
Maryland  
Medical Examiner  
for Cecil County  
M. D. or other  
Date signed 8-4-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil

City or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Rural near Elkton, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. RD 1  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Andrew Bennett Wilkinson

## 3. (b) Social Security Number

4. Sex M. 5. Color or race Wh. 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Carrie V. Wilkinson

6. (c) If alive, give age years

7. Birth data of deceased (mo., day, yr.) Aug. 5, 1867

8. AGE: Years 79 Months 11 Days 25 If less than one day hrs. min.

9. Birthplace Penna.  
(Town, county, and state)

10. Usual occupation Store Keeper

11. Industry or business

12. Name Andrew Wilkinson

13. Birthplace Pa.

14. Maiden name Sarah Murray

15. Birthplace Phila., Pa.

16. Informant Mrs. Carrie V. Wilkinson

Address Elkton R.D. 1 Md.

17. Burial Date thereof Aug 4, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillside Cem.

Location Susquehanna Rd &amp; Reagin Phila., Pa.

18. Funeral director H. W. Kippner

Address Elkton, Md.

19. August 2, 1947

(Date rec'd by registrar)

F. R. Frazer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1947, at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11:30 a. m. to Aug. 1, 1947

and that I last saw him alive on July 31, 1947

Immediate cause of death

Pulmonary Edema

Due to Cerebral hemorrhage

Due to Cardio renal vascular

Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Heber Bates, M.D.

Address Elkton Md Date signed 8/6/47

MARGIN RESERVED FOR BINDING

VS A15-9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

### 1. PLACE OF DEATH:

County.....Cecil  
City or town.....Elkton  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7/30/47 - 8/3/47  
Hospital, institution, or street address where death occurred:  
Union Hospital of Cecil Co.  
How long in hospital or institution? 7/30/47 - 8/3/47

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State.....Delaware County.....New Castle  
City or town.....Newark  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Main Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....☒

### 3. (a) FULL NAME

Victor G. Willis

### 3. (b) Social Security Number

4. Sex.....male 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Married  
6.(b) Name of husband or wife.....Mary Willis  
April 13, 1876 8.(c) If alive, give age.....68 years  
7. Birth date of deceased (mo., day, yr.).....April 12, 1876  
8. AGE: Years.....71 Months..... Days..... If less than one day..... hrs. .... min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....August 3 19..47 at 10:37 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 30 19..47 to August 3 19..47  
and that I last saw him alive on August 3 19..47

Immediate cause of death.....Cerebral hemorrhage  
DUE TO.....5 days

DUE TO.....  
DUE TO.....  
Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....  
Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....S. Ralph Andrews, Jr.  
M. D. or other

Address.....233 E. Main St., Elkton, Md. Date signed.....8/4/47

9. Birthplace.....Delaware  
(Town, county, and state)  
10. Usual occupation.....Hotel owner  
11. Industry or business.....  
12. Name.....Ops. J. Willis  
13. Birthplace.....Maryland  
14. Maiden name.....Mary Evans  
15. Birthplace.....Maryland  
16. Informant.....Mrs. Mary G. Willis  
Address.....Newark Del  
17. Burial.....Aug 6 '47  
(Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)  
Cemetery or crematory.....St Johns Cemetery  
near Newark Del  
Location.....  
18. Funeral director.....R. J. Jones  
Address.....Newark Del  
19. Aug 4 19..47 FR Trager  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

9-45-1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

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